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AUTHOR Seide, Marilyn
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ABSTRACT

This paper describes a New York State program developed to serve violent juvenile delinquents in need of mental health intervention. Since two separate state agencies had to be involved in the design and operation of this project (the Department of Mental Hygiene, which traditionally excludes "anti-social" youths from its psychiatric centers, and the Division for Youth, which is not supposed to provide "psychiatric" care), the paper questions this artificial dichotomy which fragments the ability to deliver effective services to a high-risk population. There should be an integrated service delivery system which would not "screen out" those not under one specific jurisdiction. Case histories are cited, and the validity of a theory of behavior which defines psychiatric malfunction outside of its social context is questioned. The unfortunate reliance on such factors as staff conditioning, bureaucratic (i.e., turf-defined) mandates, cost effectiveness and convenience is seen as undermining more important considerations. What should be a priority is the need to develop a systems-oriented base which encompasses developmental, cognitive, social and economic factors; parental concerns; and ego and intra-psychic factors as the basis for an effective intervention strategy. (Author)

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VIOLENT YOUTH: WHO ARE THEY, WHERE DO THEY BELONG?*

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Marilyn Seide
Sr. Program Analyst
Juvenile Justice Institute
NYS Division of Criminal
Justice Services
80 Centre Street
New York, N.Y. 10013

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VIOLENT YOUTH: WHO ARE THEY, WHERE DO THEY BELONG?

Current prevailing theory, with implications for the underlying rationale for the organization of systems. is that violence in children and adolescents and, by extension, delinquency in general, is due either to intra-psychic disturbance, which puts it in the province of the mental health field for treatment, or as behavioral (characterological), in which case it is relegated to what is commonly called social rehabilitation, or more bluntly, corrections. The criteria by which juvenile delinquents are relegated to one system or another are, at best, loosely defined and predicated on issues we shall discuss later, or, at worst, contradictory and even capricious. Different diagnostic outcomes with implications for dispositional alternatives often depend on the biases of the diagnosticians themselves, as well as, often, the setting in which the evaluation is performed and the knowledge of resources available[10]. Additionally, psychiatric disturbance is often episodic in nature, and the timing of the diagnostic

work-up may be crucial in determining the presence of mental illness. Thus, the diagnosis of "mental illness" may rest on a traditional definition made by a particular team of clinicians in a specific setting and for pre-determined purposes.

In addition to the foregoing considerations, the assumption that children and adolescents are, indeed, different in a developmental sense, is fast loosing ground throughout the country. Adolescents, particularly 14 and 15 year-olds who have come into the juvenile justice system, are loudly and broadly termed criminals, not children, and described in blood-chilling terms by the media and by self-appointed (and often elected) guardians of the public's safety as incorrigible punks no different from any hardened felon and, therefore, not entitled to different treatment. Cicourel [2] has explored this problem around several parameters, concluding that "for law enforcement officials to label a juvenile as 'bad' or a 'punk' as opposed to 'sick' means that behavioral displays enacted by the suspect must be recognized by the official as typical or 'appropriate' for involking a general rule."

With society calling for revenge and civil libertarians lately acknowledging that there is a segment of the juvenile population who may, indeed, be untreatable and not "worth" the expenditure of vast amounts of money which might be utilized more productively elsehwere, the issue has been joined. It is one of determing priorities for the utilization of what is seemingly a decreasing pot of money and resources society has available for its youth, and "bad kids" are at the bottom of the list.

Although the whole idea of developmental deficiency, lag, lacunae, un-conditioning has been brought to our attention by many professionals in the field, who warn that the teenager is, indeed, a different specimen than the adult and must be regarded and treated with this in mind [4, 8], there is, as noted, an alarming trend toward relegating 14, 15 and 16 year olds who have manifested seriously delinquent behavior to a hopeless limbo, and, at least for purposes of balancing the budget, conveniently forgetting them, at least for the time being.

This paper raises several questions regarding the validity of labelling delinquent, dangerous, violent, assaultive and possibly psychiatrically disturbed youth into particular jurisdictions on the basis of what, we will postulate, may be artificial distinctions and societal policy decisions. More broadly it asks whether the boundaries of mental health, the theme of this year's meeting, is the essential question, or, rather, whether the emphasis should be on recognizing the inter-relationship of our field with the rest of the world, and our responsibility therein.

The issue of defining, deciding who is to be treated, treating and rehabilitating the most hardcore, high risk, dangerous adolescents who have come to the attention of the juvenile justice system, has crystalized in New York State where the child caring system divides responsibility for these violent youth into two state agencies--the Department of Mental Hygiene, for those who are considered mentally ill and the

Division for Youth, for those characterized as antisocial. As a response to public pressure and community concern [9], the New York State Court-Related Unit was established in February, 1976, after long-standing preparations.[1/] It was conceived in response to the increasing alarm about violent crime reportedly committed by juveniles and the lack of facilities to contain and rehabilitate them, and saw as it target population the most violent and disturbed adjudicated male juvenile delinquents who are in need of extensive diagnostic evaluation to determine mental illness, as well as intensive therapeutic and rehabilitative intervention. This project, a colloboration between two State agencies, the Division for Youth, and the Department of Mental Hygiene, was unique in this collaboration. Neither agency previously had the services to help these youths and often had considered them not within their jurisdictions. That is, many of these juveniles had been considered unsuitable for DFY, because of the high degree of pathology present, but had also been rejected by DMH since their facilities for children who need inpatient care are not designed for assultive and violence-prone juveniles who also need a high degree of security.

A specific definition of the structure of the unit has been detailed elsehwere [11]. In short, when a youth is accepted into the unit, he enters the Department of Mental Hygiene segment of the project, called the In-Patient Diagnostic Unit, or IPDU, for a period of up to 90 days for diagnosis and stablization (all youths enter the project through

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1/ This project was funded initially with LEAA monies through the N.Y. State Division of Criminal Justice Services.

the IPDU). This unit has a capacity of 10 beds. At the end of his stay on the IPDU, a hearing is held if the youth is considered appropriate for transfer to the 18-bed Division for Youth unit, the Long Term Treatment Unit (LTTU), or he may be transferred to another DFY facility. Youths who are felt to need further long-term intensive mental hospital care are referred to other facilities within the Department of Mental Hygiene. Youths who are transferred to the LTTU are assumed to be in need of long-term rehabilitative care and spend at least nine months there.

Since this project was designed to serve the most difficult, hard-core, high risk, presumably unreachable adolescents, one may safely assume that its population would have been delegated to the most secure of the facilities operated by the Division for Youth, were this alternative not available. A few might have gained admission to a State psychiatric facility for children if a judge concluded that their behavior seemed to warrant hospitalization, but if accepted there, would have lasted only a short while since, traditionally, this type of youngster has not been able to be contained in the relatively open settings of children's hospitals, who often don't see assaultive anti-social behavior as "psychotic". Whether the services this project has provided, will, indeed, prove to have made a major impact on the future of the youngsters is crucial in determining its feasibility, and the funding agency has mounted an extensive research and evaluation effort to obtain objective data on the project's

effectiveness [11]. This effectivensss will depend on a variety of factors, including the ability to follow these youths over the next several years, their families/social situations, what after-care services are available for them, their ability to get or/and hold a job; and other considerations not related to this project but to the conditions impacting on their post-institutional lives. The fact that this particular facility exists had led to several interesting observations regarding our ability and willingness to include these youngsters within our concept of "the mental health profession", and some conclusions regarding the utility of policy-making vis-a-vis the convenience of a self-perpetating bureaucratic structure.

Lewis and Balla, reporting on their experiences as diagnosticians evaluating a population referred by the juvenile court, have written that "our clinical and epidemological findings led us to conclude that delinquency was a legal term that was used to describe a multitude of different responses to life situations ranging from adaptive to psychotic. Of special importance was our conclusion that many of the children who committed delinquent acts were seriously psychiatrically disturbed....Delinquency, when recognized as indicative of psychiatric disorder, has long been equated with sociopathic or anti-social character pathology for which no known therapy is known. There are a variety of more or less effective treatments, however, for psychosis, brain dysfunctions, neurosis, and even perhaps, some form of character pathology -

all conditions found in a significant number of delinquents. But these disorders must be recognized and distinguished from each other in order to be treated appropriately....we.... emphasized....our awareness of the potential harm of labelling, be it delinquent or psychiatric only when a so-called label, a categorization, leads to advantageous treatment for the deviant individual, to better, specific treatment and a better outcome than otherwise would have been the case, can such categorization be sanctioned ethically....Approximately one-third of the children referred to our juvenile court clinic for evaluation demonstrated clear evidence of serious psychopathology....delinquents (are) an especially psychiatrically vulnerable population. Many former delinquents were clearly at high risk for future mental illness....the juvenile justice system was, indeed, a repository for many seriously psychiatrically disturbed individuals....What emerged....was evidence that delinquency and psychopathology were often complexly intertwined."

The foregoing quote, though based on the experiences of an out-patient clinic, is strikingly similar in it's conclusions to what has been the valuable lessons learned thus far from the experiences of the Court Related Unit. The degree of disturbance and the very real possibilities of intervention, whether in DMH or DFY terms, has in itself validated the project's existence, though, as previously noted, their post-institutional careers will be crucial.

Some characteristics ofthe population with whom the CRU has dealt over the past two years are worth a look. The youths

who are referred have similar backgrounds, along several parameters. Most have histories suggesting severe parental neglect and/or abuse, with concomittant developmental lag. Almost all manifest severe learning disorders and huge cognitive deficits. Most of them manifested behavioral difficulties at a significantly early age - some as early as 3 or 4. And the multitude of non-impactful contacts with some social system--counseling agency, mental health clinic, hospital, residential or foster care agency, Division for Youth - is impressive. These interventions, when attempted, were obviously not successful--at least over the long run* When they finally came to the attention of the Court Related Unit, they were the youngsters who had fallen through all the "helping" cracks in the system -- serious, hard-core, violent, assaultive adolescents--securely labeled juvenile delinquent. If one were to categorize them in terms of potential dangerousness (although Cocozza and Steadman have definitively shown that predictors of dangerousness are notoriously unreliable [3]),using the following scale developed by Miller and Loony [7]:

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*The Juvenile Justice Institute is currently designing a study which will attempt to pinpoint institutional failure in the etiology of the boys in this project.

"(1) Have the life experiences been sufficiently traumatic to lead to resentment and bitterness?"

Answer: Yes

(2) "Does the current life situation supply a source of self-esteem?"

Answer: No

(3) "...does he like himself? Is he concerned for other people?"

Answer: No

there is sufficient cause to speculate that the prognoses are by no means optimistic, regardless which label one attaches.

The underlying assumption of the Court Related Unit, and, by extension, of those in the field whose professional lives are committed to the idea that many of these kids are salvageable, is that change is possible, intervention is essential, treatment is possible, and differential diagnosis, if recommendations are followed through, will abort the course of the youngster's life from the destructive path which has thus far been followed. This, despite all the predictors cited and the tendency today to write them off.

How do these youngsters present themselves, and why have they been accepted into such a project? A few excerpts from some screening interviews follow:

Willie was adjudicated a juvenile delinquent with a finding to Murder 2'. The referral material indicates that he was described as hyperactive at home. It is alleged that he stole and was defiant, and in school he had problems with authority and seemed unable to concentrate and pay attention. Willie presented as a tall, thin, pasty-complexioned white 14.4 year old youth with brown hair. He was a well-dressed, verbal youth who generally impressed this examiner as immature, frightened, depressed, and stubborn. His primary affect of sadness was occasionally punctuated by facial expressions of fear. He acknowledged that he was scared at the time of the interview because he did not know the reason for his presence here as well as what the future held for him. While there were times that he became somewhat animated during interchanges with the examiners, there were several instances when he refused to answer questions and would fall silent, covering his face or mouth with his hands, and was either proccupied with internal stimuli or else was clinging to an oppositional, non-compliant stance. On some occasions he seemed close to tears, but he denied experiencing sadness at these moments. Willie was oriented as to time, place, and person and sensorium appeared clear. Memory for recent and remote events appeared to be essentially intact although there was some spottiness. His social awareness and judgement manifested an impaired and erratic quality. The quality of his cognitive processes vacilated between abstract and functional. Suicdial ideation is present now and has been in the past although he denies any history of suicdial gestures or attempts. Suicdial impluses appear to arise most often when he feels angry at his father. Interestingly enough, he denies past and present homicidal ideation. Despite a history of physical abuse by his father (striking Willie in the face with closed fist), he revealed that he loves his father most of anyone. Although he readily acknowledges having committed the homicide for which he has been adjudicated, he refused to discuss in detail his thoughts, feelings, and events

leading up to, and at the time of, the homicide. He denies any dissociative experiences during the act as well as at any other time when he has acted aggressively. He categorically denies any history of encopresis and claims he has no problem at present with enuresis. He claims he does become angry when others "do things to me," but he asserts that he has never lost control while experiencing aggression. According to Willie, he has been carrying a knife with him at all times during the last two years. He related that he saw an eight year-old girl fall down a cliff. He did not know the circumstances of her having fallen down and he thought that she was dead. Subsequently, he claims he dragged her downstream and stabbed her. While stabbing this girl with whom he was acquainted, he revealed that he felt "a little different, strange." Afterwards, he reported that he felt sadness for having killed her. He offers no explanation for his behavior and it is this examiner's impression that he is withholding significant information regarding possible provocation of his act. Willie denies any history of auditory hallucinations as well as alcohol and substance abuse with the exception of marijuana. He reports some alteration of visual perception, e.g., blurriness, when under the influence of marijuana. It is not clear whether Willie experienced a visual hallucination while awake, had a hypnopompic experience, or if he had notable difficulty in differentiating a dream from reality when he had a "vision" of his grandfather who died approximately four years ago. There may be some possible difficulty in the differentiation of internally-produced stimuli from externally-derived perceptions. He does believe that people are out to get him. However, this feeling of persecution and tendency towards referential ideation has apparently not attained delusional dimensions at present. He denies preoccupation with morbid thoughts and death. In summary, Willie appears to be a childish, stubborn, obstinate youth who is possibly suffering from long-standing problems which first made their appearance in early childhood. So much about this youngster impresses this examiner as deriving from that period. This may also account for what appears to be his extensive preoccupation with separation anxiety and fear. His impaired judgement and unreliable reality testing in conjunction with a paucity of certain other ego structures render this youth a danger to himself and to others. There is adequate evidence available to constitute a presumption of serious mental illness and I recommend his admission to the IPDU for a period of observation, diagnostic assessment, treatment and

and disposition planning.

Pablo is a 15 year old Puerto Rican youth of very short stature. He was previously diagnosed "achondroplastic dwarfism." Burn scars are present on his right arm, and some scars are on his cheeks. On 9/30/77, the Family Court determined that Pablo required a restrictive placement based upon two fact findings: Manslaughter 2', Assault 1', Criminal Possession of a Dangerous Weapon 3'; and Assault 1' and Criminal Possession of a Dangerous Weapon 4'. Pablo participated readily in the interview, and related in a charming manner. He was cooperative in answering all questions. He seemed tired, and would frequently yawn. He admitted to smoking several joints of marijuana two days before the interview but denied smoking before the session. Pablo stated that his main problem is his "blown attitude." "You tell me something I don't like and I do something you don't like....I bang you with a knife, bat, chair, whatever." In addition to the adjudication for murder, Pablo mentioned other violent incidents including stabbing someone in the shoulder, and shooting somebody in the shoulder with a 16 gauge sawed-off shotgun. The shooting followed a store theft in which his cousin was beat-up while he and Pablo were caught leaving the store. In retaliation, Pablo "blew away" the attacker. The stabbing occurred in a movie theater fracas involving Pablo, several friends, and an usher. The usher had prevented Pablo from sneaking into the theater, and was bothering him after he paid to get in. The murder for which Pablo was adjudicated involved a fight with a friend with whom he had played dice and "made money." He knew the friend's entire family, and is very frightened about returning home because he believes the other family will retaliate. Pablo thinks that his only chance for survival is to return home and to kill all of the other family and friends before they get him. When asked abouthis state of mind during violent incidents, Pablo stated that his friends call him "Crazy Shorty" because he is so quick to lose his temper and fight. When asked if he thought he were crazy, he said "You tell me." He said that sometimes he could not remember the details of the violent incidents. Sometmes he felt as if something from outside entered him when he would

become angry, maybe some kind of force from the Devil. When further questioned about this, he stated that at times the Devil would say, Do it, do it", and he would hit out. He stated that sometimes in addition to feeling controlled by the Devil, he has seen him and talked with him. It was unclear from these remarks whether he was experiencing command hallucinations during violent moments, or whether he was trying to convince his audience that he should be admitted to the program. When asked about whether he wanted to come here, Pablo state, "Yes. If you could help me, I sure would appreciate it." Pablo has thought about suicide several times, but has never attempted it. The most recent time was at Strafford when he cut up a person who wanted to have sex with him, and thought of stabbing himself in the heart. Pablo admits to taking acid and cocaine as well as barbiturates. During the sensorium questions in the interview, Pablo demonstrated his awareness of time, place, and person. His judgment was antisocial and impulsive. In summary, Pablo is a person of below average to average intellectual abilities. Hs is extremely sensitive to criticism and will lash out with impulsive murderous rage if he feels that he is not treated with respect. Without treatment, there is a high probability that he will kill again. Suicidal ideation is present although there have been no attempts. The patient claims both visual and auditory hallucinations involving the Devil. Particularly noteworthy are claims of command hallucinations as well as delusions of alien control. Because of a presumption of serious mental illness combined with the violent nature of his crime, it is strongly recommended that he be admitted to the IPDU for further diagnostic workup.

Danny is a tall, well-built 15.8 year old Black youth who appeared neat and well-dressed for the interview. On 9/16/77, there was a finding to Rape 1', Sodomy 1', Robbery 2' and Burglary 1'. He has had a rather extensive legal history since 1975. Mainly he has been involved in charges of robbery and burglary. He was related to the examiners throughout the interview and appeared to attempt to cooperate to the greatest extent possible. He was oriented to time, place, and person and sensorium appeared clear. His judgment is frequently impaired and manifests implusive, hysterical qualities. His conscious

cognitive processes remain at descriptive and functional levels with a notable incapacity to arrive at more abstract conceptualizations. Danny displays a significant thought disorder in that his thinking can be described as "magical" in that he is very prone to formulating cause-effect relationships based solely on temporal contiguity. This form of thinking, typical of three and four year-olds, emerges most flagrantly when he is having to deal with death in general and with the demise of relatives in particular. He is firmly convinced that the "spirits" of the dead people do exist and enable inanimate objects to fall from shelves, electric lights to make tapping noises, to prod a cat to jump on a couch, or to produce the sound of footsteps when no one is visible. His very palpable depression and fear surrounding death became evident during the interview when he openly cried at the mention of his pre-occupation with death and with the memories of those who have died. This youth is convinced that he was born with a "veil over his face" and he asserted that he will commit suicide and join his mother in heaven within two months after she dies. Danny has become consciously aware of suicidal ideation as well as depression since being incarcerated at Juvenile Center. Although he disavows specific homicidal ideation, he categorically asserted that he will get revenge on the woman who pressed charges against him leading to his adjudication and that he will definitely hurt her in some way. He adamantly denies committing the rape with which he has been charged, but he does acknowledge multiple robberies and muggings. He sees his major problem revolving around his temper, proneness to humiliation, and his assaultiveness. Questionning during the present interview elicited the possibility that there may be times while fighting that he may lose control and possibily experience some dissociation. He denies alcohol and substance abuse as well as systematized delusional beliefs other than that mentioned above. He states that he is bothered by his low math and reading levels and wants help with his reading as well as his proneness to assaultive behavior. When asked what his three wishes were, he responded: 1) to bring back my people who have passed away; 2) to own a home for all the family; 3) to stay alive. In summary, Danny is a seriously depressed youth who exhibits a notable magical thinking in conjunction with pre-occupation with morbid

thoughts. His aggressive behavior seems to have significantly intensified sincethe time of his uncle's death. His affective state, thinking processes, and serious sympton picture point to a presumption of serious mental illness sufficient to warrant his admission to the IPDU. Unresolved diagnostic issues as well as disposition planning augment recommendation for his admission for a period of observation, evaluation, diagnostic assessment, and treatment planning.

Sam began serving a six month sentence at Rikers Island for Unauthorized Use of a Motor Vehicle on 7/27/77. A family court judge placed him with DFY on 10/17/77, and on 9/6/77 there was a finding to a Designated Felony, Attempted Murder 2'. He has a three year Restrictive Placement which is to commence at the end of his current sentence. Sam is a fairly tall, well-built 16.5 year old Black youth who was appropriately dressed for the interview and appeared to try to cooperate with the examiners. He was oriented to time, place, and person and sensorium was clear. He is a verbal, farily articulate young man who was related to the examiners and displayed an appropriate range of affect, although a depressive quality underlays most of his presentations. His judgment was at times erratic and showed impairment, especially when anti-social features were able to intrude. Although there is some unevenness in the level of his secondary process thinking, Sam displayed relatively high-level conceptual and abstracting abilities. Sam's reported history of horrible abuse, neglect, physical beatings, and manipulation by his mother has created a fertile context for the emergence of a variety of psychopathology. Not only did his mother send him out to steal, but he also reportes that her beatings of him sometimes left him a dazed state where there was a possible loss of consciousness. The reported history of "blackouts" is based on his "fainting when I didn't want to and couldn't stand to hear my mother talking and yelling at me." He reports that his past history of sef-inflicted or self-initiated injuries that occurred up to age 11 were engineered by him so that he could go to a hospital and get out of his mother's house. The most recent evidence of suicidal ideation occurred while he was incarcerated on Rikers Island. Sam asserts that he has been able to impose much greater control over his impulses and assaultive behavior since February of this year. He acknowled-

ges that prior to this time he inadvertantly killed a woman during a pocket-book snatching and intentionally assaulted another woman with a meat cleaver. He reports hearing a woman's voice calling his name when he is in deep thought--it does not appear that this repeated experience is truly hallucinatory in nature. Upon questionning, Sam revealed that he does worry about going crazy and that the craziest thing he does is to "steal too much." In addition, he often feels as if bugs are crawling all over him. Sam marks an intensification of his anti-social activities and assaultive behavior as having occurred shortly after his father's death in 1974. In summary, Sam appears to be the victim of extreme abuse and neglect whose loneliness, isolation, and feelings of betryal have led to a marked chronic depression out of which has sprung a multitude of aggressive and anti-social personality components and behaviors. Despite his history of profoundly distorted relationships with significant others, Sam still seems to retain a capacity for relatedness to others and there does seem to be some potential for establishing a therapeutic relaitonship. This youth states that he would like to talk to someone about his feelings and thought he could derive some benefit from that. Although Sam presents some very marked anti-social qaulities, it is my impression that his aberrant behavior couldbe quite symptomatic in nature. The daignosis of this youth is not at all clear and the Family Court Mental Health Services mentions the possibility of Psychomotor Epilsepy. I would recommend Sam's admission to the IPDU for a period of observation, assessment, diagnosis, and treatment planning.

Jimmy has been a patient at a Children's Psychiatric Center since 7/6/77. He is awaiting disposition of a J.D. Petition (Burglary) and a PINS Petition (Beyond Control of Mother). On 6/29/77, Jimmy had a fight with his brother, threw a knife at him, was forcibly subdued and taken to a municipal hospital. At the hospital he was so disruptive that he was brought to Family Court, who remanded him to a DFY detention facility. In the intervening days, Jimmy was so difficult to manage that he was transferred from detention to an inpatient psychiatric unit and then back to the psychiatric center he was previously in when a bed was available. The referral material notes that Jimmy is the product of a very disturbed, chaotic family with severe emotional deprivation, neglect

and rejection. In his various placements he is described as a rather difficult, hostile youngster who has a high potential for responding to angry feelings through assaultive behavior on peers and adults. There were two prior periods of institutionalization in a residential treatment center. Jimmy is small in stature and has been diagnosed as having hypogonadatropic hypogonadism - a genetic deficiency. In the interview, he was cooperative and verbal but seemed to be rather controlled and careful of his responses. He tended to externalize and rationalize his propensity for violence. He volunteered that he smokes marijuana and drinks five to six quarts of beer daily when at home. There was no evidence of a thought disorder, delusions or hallucinatory phenomena. I am recommending Jimmy's admission to the IPDU for observation, evaluation, treatment assessment and dispositional planning. There is a documented pattern of increasing violence, there are diagnostic ambiquities and a genetic/hormonal condition which requires further examination and clarification.

These vignettes certainly bear out Chwast's [1] conclusion that "In criminal and delinquent acting out, both psychodynamic and sociodynamic influences are often inseparably linked." But the direction intervention takes is far too dependent on the luck of the draw.

Halleck [5] is "not impressed with either the accuracy or value of classifications of delinquency. Categorizations sometimes provide clarity but it neglects considerations of the unitary nature of disturbed behavior....All psychotic clarifications seem to rely upon judgments of the degrees of unreasonableness of the delinquent's behavior. Socialized or environmentally determined delinquents are described as behaving in a more reasonable manner than unsocialized delinquents.... it is easy for behavioral scientists to convince themselves that they are dealing with significantly different groups...There

is so much interrelationship and a mixture between artifically defined categories of delinquency that it is difficult to appreciate their meaningfulness and usefulness." Winnicott [12] states unequivocally, "The antisocial tendency is not a diagnosis. It does not compare directly with other diagnostic terms such as neurosis and psychosis. The anti-social tendency may be found in a normal individual, or in one that is neurotic or psychotic."

The distinctions between "bad" and "mad" become increasingly blurred as one investigates further, studying what research has been done thus far and thus investigating the backgrounds, profiles and case histories of the population in the Court Related Unit. What emerges is that the theory of behavior as determined by psychiatric malfunction vs behavior as primarily socially defined and determined sets up an artificial dichotomy. The weight of the evidence shows not simply the common factors in the etiologies of these youth but alsothe fact that anti-social and even violent behavior and symptoms are episodic and often unpredictable, and that some anti-social behavior stems from resistance, defiance, lack of respect for others while at other times the same behavior is a product of inner turmoil and conflict, often psychotic in nature; that focusing on one aspect of the total personality/picture of the child eliminates the ability to look at the total picture, and, therefore, reinforces our own narrow jurisdictions, making a total approach impossible, though a holistic attempt is the only kind of intervention that can possibly be effective.

One of the seemingly simplistic lessons to be learned from the experiences of the NYS Court Related Unit is that if a program is designed to treat/rehabilitate/intervene with/ accept a certain type of resident, the applicant will get the service offered. If your mandate is to develop and operate an out-patient service for 9 year-old hispanic girls with Down's Syndrome, who are left-handed and like to play with Pekinese dogs, then these children will have a place which not only accepts, but is eager to treat them. If your charge is less specific, who gets service will depend to a large extent on the conditioning of the staff, on bureaucratic and cost-effective considerations, on location of the service, etc. It is impossible to operate a child-caring (or adult-caring) system which rests on such a capricious, illogical and fragmented foundation. That a program currently exists which is providing quality services to a heretofore ignored and denigrated population is the good news. The bad news is that when we conceive of services in such a fragmented, uncohesive manner, no matter now excellent the particular, encompassed service offered, what happens next?

The full provision of mental health - one should perhaps leave out the word mental - services to children should emanate from one single auspice as the bottom line for developing a cohesive system. A central office of accountability should be charged with assuring the provision of services through the development of a range of programs dictated by the needs of the youth involved. And these needs need a much less restrictive categorization, beginning with the concept that children

are responsive to intervention whatever their deviant manifestations might be. Looked at from a systems base, including considerations of development, social and economic factors, parental considerations, cognitive development, and ego and intra-psychic factors, programs must be developed from a coordinated and well-planned base. For those most severly disturbed, whether manifesting this by their extreme antisocial behavior or by their more "traditional" mental illness, there would be the additional essential element of careful, appropriate follow-up and support services. Many of these youths will be chronic in their illness or deviance, depending on stress, and should have the back-up of institutional options when aftercare has identified them as needing such. This, in the end, will prove far less costly than the life-time institutionalization or possible life-threatening behavior which would be the most likely eventuality without careful, relevant planning, intervention, effective accountability, and realistic concern.

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